Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
Liberty Mutual Fire Insurance

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-10-4409-01

MFDR Date Received
June 17, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier is required to reimburse Provider $5,735.28 pursuant to the Outpatient Fee Guideline. The Carrier made a partial payment of $3,864.71. Therefore, the Carrier is required to reimburse Provider an additional amount of $1886.04, plus any and all applicable interest."

Amount in Dispute: $1,886.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Vista Hospital of Dallas has been appropriately reimbursed for services rendered."

Response Submitted by: Liberty Mutual Fire Insurance. 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2009	Outpatient Hospital Services	$1,886.04	$1,886.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 9, 2009

- X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE.
- B406 – DOCUMENTATION NOT SUBMITTED OR INSUFFICIENT TO ACCURATELY REVIEW THIS BILL.
- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
- Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- B398 – THIS PROCEDURE IS INCLUDED IN THE PRIMARY PROCEDURE.
- X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED.
- U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES.

Explanation of benefits dated November 25, 2009

- X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES AER PAYABLE.
- X901 – X901 DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED.
- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
- X129 – PROCEDURE NOT DOCUMENTED IN OPERATIVE REPORT
- Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE
- B398 – THIS PROCEDURE IS INCLUDED IN THE PRIMARY PROCEDURE
- U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J3490, date of service July 8, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code A4649, date of service July 8, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code A4649, date of service July 8, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code 87070, date of service July 8, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.57. 125% of this amount is $15.71. The recommended payment is $15.71.
- Procedure code 29880, date of service July 8, 2009, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $1,943.12. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,165.87. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,144.42. The non-labor related portion is 40% of the APC rate or $777.25. The sum of the labor and non-labor related amounts is $1,921.67. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.246. This ratio multiplied by the billed charge of $1,524.00 yields a cost of $374.90. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,921.67 divided by the sum of all APC payments is 66.67%. The sum of all packaged costs is $7,563.45. The allocated portion of packaged costs is $5,042.29. This amount added to the service cost yields a total cost of $5,417.19. The cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $2,054.27. 50% of this amount is $1,027.14. The total APC payment for this line, including outlier payment, is $2,948.81. This amount multiplied by 200% yields a MAR of $5,897.61.
- Procedure code 29879, date of service July 8, 2009, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $1,943.12. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,165.87. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,144.42. The non-labor related portion is 40% of the APC rate or $777.25. The sum of the labor and non-labor related amounts is $1,921.67. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.246. This ratio multiplied by the billed charge of $1,524.00 yields a cost of $374.90. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $960.84 divided by the sum of all APC payments is 33.33%. The sum of all packaged costs is $7,563.45. The allocated portion of packaged costs is $2,521.16. This amount added to the service cost yields a total cost of $2,896.06. The cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,214.59. 50% of this amount is $607.30. The total APC payment for this line, including outlier payment and multiple-procedure discount, is $1,568.14. This amount multiplied by 200% yields a MAR of $3,136.27.
- Procedure code 29876, date of service July 8, 2009. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “for coding, billing, reporting and reimbursement of professional medical services. Texas Workers’ Compensation system participants shall apply the following; (1) Medicare payment policies, including its coding; billing; … and other payment policies in effect on the date a service is provided…” The medical bill for the service in dispute included the “59” modifier. American Medical Association Current Procedural Terminology (AMA CPT) describes the 59 modifier for use in identifying procedures/services that are not normally reported together, and that are not ordinarily encountered or performed on the same day by the same physician. According to Medicare Learning Network Matters (MLN) Number, SE0715, these would include a different session or patient encounter, procedure or surgery, site or organ system; or a separate incision/excision, lesion, or injury (or area of injury in extensive injuries). The medical documentation including the document titled “Operative Report” was reviewed but did not support the service in dispute represents a separate service. The division concludes that the requestor did not meet the requirements of §134.203(b)(1). No payment can be recommended
- Procedure code 94762, date of service July 8, 2009, has a status indicator of Q1, which denotes STVX-

packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure code 29880 billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.

- Procedure code 94760, date of service July 8, 2009, is unbundled. Payment for this service is included in the payment for the primary procedure (29880). A modifier is not allowed. Separate payment is not recommended.

4. The total allowable reimbursement for the services in dispute is $9,049.59. The amount previously paid by the insurance carrier is $3,864.71. The requestor is seeking additional reimbursement in the amount of $1,886.04. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,886.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,886.04, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		April 5, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.